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OPIOID TREATMENT SERVICES / MEDICATION ASSISTED TREATMENT
SUPPLEMENT

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SUPPLEMENT

On April 1, 2017, Virginia’s Medicaid program launched an enhanced substance use disorder treatment benefit - **Addiction and Recovery Treatment Services (ARTS)**. The ARTS benefit provides treatment for those with substance use disorders across the state. The ARTS benefit expands access to a comprehensive continuum of addiction treatment services for all enrolled members in Medicaid, FAMIS, FAMIS MOMS and the Governor’s Access Plan (GAP), including expanded community-based addiction and recovery treatment services and coverage of inpatient withdrawal management and residential substance use disorder treatment.

The **ARTS benefit increases access to Medication Assisted Treatment**, the **evidence-based combination of medication, counseling, and psychosocial supports** that results in the highest chances of recovery by recognizing Opioid Treatment Programs (OTPs), Preferred Office-Based Opioid Treatment (OBOT) Providers, and Preferred Medication Assisted Treatment Providers. DMAS is recognizing Preferred providers across the Commonwealth that have licensed behavioral health professionals providing co-located counseling and “high touch” care coordination at the same clinic as buprenorphine-waivered practitioners to members with opioid use disorder. DMAS is posting a list of these approved providers online at: http://www.dmas.virginia.gov/Content_pgs/bh-home.aspx.

OPIOID TREATMENT SERVICES

The purpose of this supplement is to provide specific information on Opioid Treatment Services (OTS). As defined by the American Society of Addiction Medicine (ASAM), OTS means Opioid Treatment Programs (OTPs), Office Based Opioid Treatment (OBOT), and Medication Assisted Treatment provided by Buprenorphine Waivered Practitioners independent from OBOT and OTP settings.

Opioid Treatment Programs (OTPs)

OTPs are programs certified by the United States Substance Abuse and Mental Health Services Administration (SAMHSA) that engage in supervised assessment and treatment, using methadone, buprenorphine, L-alpha acetyl methadol, or naltrexone, of members who are addicted to opioids (12VAC30-130-5020). OTS includes the use of Medication Assisted Treatment (MAT) in addition to the psychotherapy services to treat a member with an opioid use disorder.

Preferred Office Based Opioid Treatment (OBOT) Providers

OBOT Providers, also known as “Preferred OBOTs”, deliver addiction treatment services to members with moderate to severe opioid use disorders provided by buprenorphine-waivered practitioners working in collaboration and co-located with licensed Credentialed Addiction Treatment Practitioners providing psychosocial treatment in public and private practice settings (12VAC30-130-5020).

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In-Network Buprenorphine Waivered Practitioners Practicing Independently of an OTP and Preferred OBOT

Buprenorphine waived practitioners who are delivering Medication Assisted Treatment (MAT) independent from an OTP or Preferred OBOT setting, shall be in-network providers enrolled with DMAS and credentialed with the Medicaid Managed Care Organizations (MCOs) and Magellan of Virginia to be reimbursed for delivering MAT.

PROVIDER ENROLLMENT

To become an in-network provider of OTS with the DMAS contracted MCOs and BHSA, providers must be credentialed and enrolled according to all applicable MCO, BHSA and DMAS standards. Providers are subject to applicable Department of Health Professions and DBHDS licensing requirements. DMAS provider enrollment is located:

<https://www.viriniamedicaid.dmas.virginia.gov/wps/portal/WebRegistration>.

Please note that providers should also be enrolled with DMAS to be able to be reimbursed for laboratory services for fee-for-service and Governor's Access Plan (GAP) members that the BHSA does not cover.

Additionally, any licensed practitioner joining a contracted group practice or a contracted organization adding a newly licensed location must also become credentialed with the MCOs and the BHSA prior to rendering services. To initiate the application process for the MCOs and the BHSA or for questions related to contracting and the credentialing process, providers should contact the specific MCOs and the BHSA.

In addition to following all general provider requirements outlined in Chapter II of this manual, OTS providers must meet the applicable requirements listed below.

All providers of the OTS services listed below shall submit the appropriate ARTS Attestation Packet to the MCOs and the BHSA to initiate the credentialing process. The ARTS Attestation Forms and Staff Roster are posted online at: http://www.dmas.virginia.gov/Content_pgs/bh-cred.aspx.

- **Opioid Treatment Programs (OTPs)** – OTPs must submit the ARTS Attestation Form for Opioid Treatment Programs, ARTS Staff Roster and copy of relevant DBHDS license directly to the MCOs and BHSA to begin the credentialing process.
- **Preferred Office Based Opioid Treatment (OBOTs) Programs** – Preferred OBOTs must be recognized in a multi-step process. The first step is recognition of the Preferred OBOT by the DMAS Panel of Addiction Credentialed Physicians. Providers shall submit the ARTS Preferred Office Based Opioid Treatment Program Attestation Form (including

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the Weekly Provider Schedule), ARTS Preferred OBOT Organizational Staff Roster, and the ARTS Preferred OBOT Credentialing Checklist directly to DMAS.

Once providers have received recognition from DMAS for the Preferred OBOT status, the second step is credentialing of all buprenorphine-waivered practitioners and licensed behavioral health professionals on the Preferred OBOT staff roster by the MCO and BHSA. Final approval is contingent on the individual practitioners and professionals fully completing the credentialing process with the MCOs and BHSA. Continued participation as a Preferred OBOT is contingent on providers maintaining their credentialed or contract status with the MCOs and BHSA, as well as meeting the standards of care and best practices specified in the ARTS Regulations and ARTS Provider Manual.

Monthly Preferred OBOT Redcap Survey

Preferred OBOTs approved by DMAS, shall complete the OBOT Redcap Survey within 30 days from the date of the preferred OBOT recognition letter. Each **Preferred OBOT must initially complete the demographic info and enter all their buprenorphine-waivered practitioners and licensed behavioral health providers and their capacity for new patients.** Each Preferred OBOT must update the Redcap Survey **at least monthly** with their capacity and any new or removed buprenorphine-waivered practitioners and licensed behavioral health providers. This Redcap Survey is critical for timely reimbursement of Preferred OBOTs and to ensure access to care. If the Preferred OBOT does not update the Redcap Survey at least **monthly**, it may will delay reimbursement for services and may result in loss of Preferred OBOT recognition by DMAS. For more information about the Redcap Survey process, please email: OBOTRedcap@dmass.virginia.gov.

- **Buprenorphine-waivered practitioners delivering MAT independently of an OTP or Preferred OBOT** do not need to submit an Attestation Form. These practitioners should credential directly with the MCOs and BHSA.

Opioid Treatment Programs (OTP)

OTP providers shall be licensed by the Department of Behavioral Health and Developmental Services (DBHDS) as a provider of Medication Assisted Treatment/Opioid Treatment Services and contracted by the MCOs and the BHSA as an ARTS OTP Provider.

The ARTS specific procedure codes and reimbursement structure for OTP services are posted online at: http://www.dmass.virginia.gov/Content_pgs/bh-home.aspx.

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In addition, OTP providers shall meet the following criteria:

1. Staff requirements for OTP programs shall meet the licensing requirements of 12VAC35-105-925. The interdisciplinary team shall include Credentialed Addiction Treatment Professionals acting within the scope of their practice and trained in the treatment of opioid use disorder including an addiction credentialed physician and as defined in 12VAC30-130-5020.

OTPs may also utilize Certified Substance Abuse Counselors (CSACs) in their practice to provide substance use disorder counseling and psychoeducational services within their scope of practice. CSACs may not practice autonomously and shall be supervised according to Board of Counseling requirements.

2. Staff shall be knowledgeable in the assessment, interpretation, and treatment of the biopsychosocial dimensions of alcohol or other substance use disorders.

A physician or physician extender, as defined in 12VAC30-130-5020, shall be available during medication dispensing and clinical operating hours, in-person or by telephone.

OTPs that are providing prescriptions for Buprenorphine products are required to be approved as a Preferred Office Based Opioid Treatment (OBOT) provider to waive the service authorization requirement at the pharmacy for their members.

Preferred Office Based Opioid Treatment (OBOT)

Preferred Office-Based Opioid Treatment (OBOT) services shall be provided by a buprenorphine-waivered practitioner and a co-located licensed Credentialed Addiction Treatment Professional and may be provided in a variety of practice settings including primary care clinics, outpatient health system clinics, psychiatry clinics, Federally-Qualified Health Centers (FQHCs), Community Service Boards, local health department clinics, and physicians' offices. The practitioners shall be credentialed by the MCOs and the BHSA. Preferred OBOT providers do not require a separate DBHDS license.

The ARTS specific procedure codes and reimbursement structure for Preferred OBOT services are posted online at: http://www.dmas.virginia.gov/Content_pgs/bh-home.aspx.

In addition, Preferred OBOT services providers shall meet the following criteria.

1. The buprenorphine-waivered practitioner licensed under Virginia law shall have completed one of the continuing medical education courses approved by the Center for Substance Abuse Treatment and obtained the waiver to prescribe or dispense

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buprenorphine for opioid use disorder required under the Drug Addiction Treatment Act of 2000 (DATA 2000). The practitioner must have a DEA-X number issued by the Drug Enforcement Agency that is included on all buprenorphine prescriptions for treatment of opioid use disorder.

- a. Licensed physicians must have completed the 8-hour training course approved by the Substance Abuse and Mental Health Services Administration (SAMHSA) and obtained a waiver to prescribe buprenorphine for opioid use disorder from the Drug Enforcement Administration (DEA).
- b. Licensed Physician's Assistants or Nurse Practitioners must have completed the 24 hours of training required by SAMSHA and obtained a waiver to prescribe buprenorphine for opioid use disorder from the DEA. Physician Assistants and Nurse Practitioners, who have obtained a SAMHSA waiver, shall only prescribe buprenorphine for opioid addiction pursuant to a practice agreement with a waived doctor of medicine or doctor of osteopathic medicine as in accordance to the Board of Medicine regulations (12VAC85-21-130).

2. **Licensed Credentialed Addiction Treatment Professionals must be co-located at the same practice site as the buprenorphine waived practitioner.** The licensed Credentialed Addiction Treatment Professional, under the scope of their practice, provides psychotherapy and counseling during clinic sessions when the buprenorphine-waivered practitioner is prescribing buprenorphine or naltrexone to patients with opioid use disorder. The licensed Credentialed Addiction Treatment Professional shall work in collaboration with the buprenorphine-waivered practitioner who is prescribing buprenorphine products or naltrexone products to individuals with moderate to severe opioid use disorder.

Preferred OBOT providers may also utilize Certified Substance Abuse Counselors (CSACs) in their practice to provide substance use disorder counseling and psychoeducational services within their scope of practice. CSACs may not practice autonomously and shall be supervised according to Board of Counseling requirements.

Psychotherapy can be provided via telemedicine or a Preferred OBOT satellite location in rural areas if the nearest licensed Credentialed Addiction Treatment Professional is located more than 60 miles away from the buprenorphine waived practitioner, or members are having to travel more than 60 miles to the licensed Credentialed Addiction Treatment Professional. The licensed Credentialed Addiction Treatment Professional must develop a shared care plan with the buprenorphine-waivered practitioner and the patient and take extra steps to ensure that care coordination and interdisciplinary care planning are occurring.

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Community Service Boards and Federally-Qualified Health Centers are not required to have the licensed Credentialed Addiction Treatment Professional co-located at the same practice site and provide counseling during clinic sessions when the buprenorphine-waivered practitioner is prescribing buprenorphine or naltrexone to patients with opioid use disorder. The licensed Credentialed Addiction Treatment Professional must be employed by the same organization and provide counseling to patients prescribed buprenorphine or naltrexone. The licensed Credentialed Addiction Treatment Professional must engage in interdisciplinary care planning with the buprenorphine-waivered practitioner including working together to develop and monitor individualized and personalized treatment plans that are focused on the best outcomes for the patient.

3. Pharmacists can serve as a member of the interdisciplinary team. Pharmacists can advise buprenorphine-waivered practitioners on the selection of buprenorphine vs naltrexone as treatment options, assist with buprenorphine induction and dose adjustments, contribute to the development of the interdisciplinary treatment plan, and assist with monitoring, communicating with, and educating patients.
4. Credentialed addiction treatment professionals shall be employed by or have a contractual relationship with the buprenorphine-waivered practitioner or the organization employing the practitioner.

Preferred OBOTs shall not dispense or prescribe Methadone for treatment of opioid use disorder, as this is only allowed by a DBHDS licensed OTP. OBOTs may dispense buprenorphine products on-site **only** during the induction phase and then shall prescribe buprenorphine products after the induction phase. Community Service Boards (CSBs)/ Behavioral Health Authorities (BHAs) and any other Preferred OBOT Providers who are dispensing buprenorphine products under the license of their buprenorphine-waivered practitioners do not need to obtain an OTP license from DBDHS. If the CSB/BHA or other Preferred OBOT Provider is dispensing Methadone, the CSB/BHA or other Provider shall modify its license to include a DBDHS OTP license per Article 1 Code of Virginia 12VAC35-105-295.

Substance Use Care Coordination (G9012) for OTPs and Preferred OBOT Settings

Substance Use Care Coordination is required in Preferred OBOT settings and is optional in OTP settings. Preferred OBOTs or OTPs may bill for substance use care coordination if they meet all provider and documentation requirements. **Providers must use the DMAS IPOC forms to support billing Substance Use Care Coordination (G9012).** Substance Use Care Coordination may not be billed if the member is currently receiving Substance Use Case Management services (H0006).

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Provider qualifications for a Substance Use Care Coordinator include:

1. At least a bachelor's degree in one of the following fields (social work, psychology, psychiatric rehabilitation, sociology, counseling, vocational rehabilitation, human services counseling) and at least either 1) one year of substance use related direct experience providing services to individuals with a diagnosis of substance use disorder or 2) a minimum of one year of clinical experience working with individual with co-occurring diagnoses of substance use disorder and mental illness; or
2. Licensure by the Commonwealth as a registered nurse with at least either 1) one year of direct experience providing services to individuals with a diagnosis of substance use disorder or 2) a minimum of one year of clinical experience working with individuals with co-occurring diagnoses of substance use disorder and mental illness; or
3. Board of Counseling Certified Substance Abuse Counselor (CSAC) or CSAC-Assistant under supervision as defined in 18VAC115-30-10 et seq.

All Substance Use Care Coordinators must be under the general supervision of a buprenorphine waived practitioner or Licensed Credentialed Treatment Professional in the OTP or Preferred OBOT setting. Substance Use Care Coordinators shall be employed by or have a contractual relationship with either the buprenorphine waived practitioner or Licensed Credentialed Treatment Professional or the organization employing the buprenorphine waived practitioner or Licensed Credentialed Treatment Professional.

New Preferred Medication Assisted Treatment Providers

Residential treatment (ASAM Level 3.1, 3.3, 3.5 and 3.7), Intensive Outpatient (ASAM Level 2.1) and Partial Hospitalization (ASAM Level 2.5) providers, who are providing Medication Assisted Treatment (MAT) and who are currently credentialed with the MCO or the BHSA as an ARTS provider, can apply to be a “**Preferred Medication Assisted Treatment Provider**”. The Preferred MAT status will allow the buprenorphine waived practitioner of the facility to **prescribe buprenorphine related products to be filled at local pharmacy and be waived from having to complete the service authorization process for specific buprenorphine products**. The Preferred MAT provider must meet the service requirements as a Preferred OBOT provider documented in this Supplement. The Preferred Medication Assisted Treatment attestation packet is located online at: http://www.dmas.virginia.gov/Content_pgs/bh-cred.aspx.

Providers should complete these forms and send to **DMAS at fax: 804-452-5450** for the physician team to review for decision. If DMAS approves the application, DMAS will notify the MCOs and the BHSA. Providers will still need to complete the credentialing process with each MCO and the BHSA to ensure that the buprenorphine waived practitioners are credentialed to be reimbursed for the professional services and waive the buprenorphine service authorization.

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In-Network Buprenorphine Waivered Practitioners Practicing Independently of an OTP and Preferred OBOT

Buprenorphine waived practitioners shall be credentialed by the MCOs and DMAS. Buprenorphine waived practitioners who provide MAT for fee-for-service or GAP enrolled members and who are psychiatrists, shall also be enrolled with the BHSA as the BHSA credentials and reimburses psychiatrists. Please note for laboratory services that the BHSA does not cover, practitioners need to be enrolled with DMAS for reimbursement. DMAS will also complete the federal screening requirements as noted in Chapter II of this Manual.

The ARTS specific procedure codes, reimbursement structure and service authorization requirements for MAT services delivered independently of an OBOT or OTP setting are posted online at: <http://www.dmas.virginia.gov/Content/pgs/bh-home.aspx> and included as an Appendix to this Supplement.

If not currently enrolled with DMAS, providers must complete a provider enrollment request with DMAS via the online enrollment through the DMAS Virginia Medicaid web-portal. If a provider is unable to enroll electronically through the web, they can download a paper application from the Virginia Medicaid web-portal and follow the instructions for submission. Please go to www.virginiamedicaid.dmas.virginia.gov to access the online enrollment system or to download a paper application.

DMAS strongly encourages providers to enroll or make updates electronically via our web portal. An application for participation submitted on paper will add additional time to the processing of your enrollment and to your request to update your provider file.

Please note: If you are planning to enroll via the paper enrollment process, DMAS will only accept the provider enrollment applications that have the provider screening questions listed. Previous versions of the provider enrollment applications that do not have the provider screening regulation questions will not be accepted and will be rejected with a request to submit the version that is currently posted on the Virginia Medicaid Web Portal at: www.virginiamedicaid.dmas.virginia.gov.

If you have any questions regarding the online or paper enrollment process, please contact the Conduent Provider Enrollment Services at toll free 1-888-829-5373 or local 1-804-270-5105.

All participating Medicaid providers are required to complete a new contract agreement as a result of any name change or change of ownership.

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Out-Of-Network Providers

DMAS is strongly encouraging the MCOs to transfer members from out-of-network clinics who are requiring members to pay out-of-pocket, to Preferred OBOTs, OTPs, and other in-network buprenorphine-waivered practitioners if an in-network provider is available within 30 miles in an urban area and 60 miles in a rural area (which meets DMAS network adequacy standards for MCOs). The MCO will cover all the members' addiction treatment services (e.g., physician visits, laboratory tests, counseling, medication, care coordination, etc.) instead of members needing to pay out of pocket to out-of-network providers. The MCOs will also pay for transportation for members to and from their appointments to in-network providers. This increased access to Preferred OBOT Providers and OTPs will ensure that members receive evidence-based Medication Assisted Treatment including counseling and psychosocial supports, as well as the "high touch" care coordination that will result in the best outcomes.

MEDICAL NECESSITY CRITERIA

In order to receive reimbursement for OTS, the member shall be enrolled in Virginia Medicaid and shall meet the following medical necessity criteria below:

- The member shall have a primary International Classification of Diseases (ICD-10) diagnosis of moderate to severe opioid use disorder or be a pregnant woman with any opioid use.
- The member shall be assessed by a Credentialed Addiction Treatment Professional acting within the scope of their practice, who will determine if the severity and intensity of treatment requirements as defined by the most current version of the American Society of Addiction Medicine (ASAM) Treatment Criteria for Addictive, Substance-Related and Co-Occurring Conditions (Third Edition, 2013) is met.

Please note that Preferred OBOTs are required to develop an interdisciplinary plan of care (IPOC) using the DMAS IPOC form by a Credentialed Addiction Treatment Professional, including the delivery of Substance Use Care Coordination (G9012). OTPs are required to use the DMAS IPOC for purposes to support billing for Substance Use Care Coordination (G9012). The DMAS IPOC forms is further defined later in this Supplement and posted online at: http://www.dmas.virginia.gov/Content_pgs/bh-pm.aspx.

COVERED SERVICES

Opioid Treatment Programs (OTP)

OTPs shall meet the service components and risk management requirements outlined below and as defined in 12VAC30-130-5050. Providers shall also meet the Department of Behavioral

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Health and Developmental Services Regulations for Licensing Providers (12VAC35-105-925 – 1130).

- Link the member to psychological, medical, and psychiatric consultation as necessary to meet the member's needs.
- Ensure access to emergency medical and psychiatric care through connections with more intensive levels of care.
- Ensure access to evaluation and ongoing primary care.
- Conduct or arrange for appropriate laboratory and toxicology tests including urine drug screenings.
- Ensure appropriately licensed and credentialed physicians are available to evaluate and monitor use of methadone, buprenorphine products or naltrexone products and of pharmacists and nurses to dispense and administer these medications.
- Ensure buprenorphine monoproduct is prescribed only to pregnant women or for 7 days while transitioning members from methadone to buprenorphine/naloxone. All other members should receive buprenorphine/naloxone products. The maximum daily buprenorphine or buprenorphine/naloxone dose should be 16 mg unless there is documentation of an ongoing compelling clinical rationale for a higher maintenance dose up to maximum of 24 mg. In rare and isolated cases, if a practitioner prescribes the monoproduct to a non-pregnant member because it is clinically indicated, the medication and visit will still be covered.
- Ensure medication for other physical and mental health conditions are provided as needed either on-site or through collaboration with other providers.
- Provide individualized, patient-centered assessment and treatment.
- Assess, order, administer, reassess, and regulate medication and dose levels appropriate to the member; supervise withdrawal management from opioid analgesics, including methadone, buprenorphine products or naltrexone products; and oversee and facilitate access to appropriate treatment for opioid use disorder.
- Provide cognitive, behavioral, and other substance use disorder-focused therapies, by a Credentialed Addiction Treatment Professional, reflecting a variety of treatment approaches, provided to the member on an individual, group, or family basis.
- Provide **optional Substance Use Care Coordination (G9012)** described below and use the DMAS IPOC form to support billing for G9012. If providers choose not to provide the level of care coordination to bill G9012, they must still ensure members are being referred to necessary services in the community and there is coordination of care among the interdisciplinary team monthly. CSBs/BHAs that are licensed as Substance Use Case Management providers **may choose** to provide Substance Use Case Management services (H0006) instead of Substance Use Case Coordination. **Substance Use Care**

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Coordination cannot be provided and billed simultaneously with Substance Use Case Management.

- Provide on-site screening or referral for screening for infectious diseases such as HIV, Hepatitis B and C, and tuberculosis at treatment initiation and then at least annually or more often based on risk factors for members who have not been screened for infectious diseases within previous 12 months.
- Medication administration on site during the induction phase must be provided by a Registered Nurse (RN). Medication administration during the maintenance phase may be provided either by a RN or Licensed Practical Nurse (LPN). Please note per the Virginia Board of Nursing, an LPN can collect clinical data, but not be able to draw conclusions and/or diagnosis.

OTP risk management shall include the following activities which must be clearly and adequately documented in each member's record:

- Conduct random urine drug screening for all members, conducted at least eight times during a twelve-month period as defined in 12VAC35-105-980.
- Check the Virginia Prescription Monitoring Program at least quarterly for all members.
- Provide opioid overdose prevention education, including the prescribing of naloxone.

Service Units and Limitations

- See ARTS Reimbursement Structure for billing codes and units for OTP services is available online: http://www.dmas.virginia.gov/Content_pgs/bh-sud.aspx.
- OTPs may bill the H0014 MAT induction code for three separate inductions per 365 calendar days per member that must be at least 90 calendar days apart. H0014 includes the physician/physician extender services only. This does not cover the medications as part of the induction. The first day of each induction is billed using H0014. Additional physician visits within a 365 calendar day period shall be billed using the appropriate evaluation and management code. Thus providers would submit H0014 for day one of induction, and the appropriate evaluation and management code on day two and after. Providers can bill for additional inductions beyond 3 separate inductions per 365 calendar days using the appropriate evaluation and management codes. If a member fails three inductions within a 365 calendar day period in an OTP setting, the provider should consider referring the member to a higher level of care for assessment for treatment.
- Group psychotherapy has a maximum limit of 10 members per group. Such counseling shall focus on the needs of the members served.
- For substance use counseling and psychoeducational groups, the recommended group size limit is 10 but DMAS will allow for a larger group with the expectation that group

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size and composition should be based on the needs of the group members and determined using standards of care.

- The buprenorphine waived practitioner **shall not bill** for the MAT induction (H0014)) and psychotherapy or opioid counseling (H0004 or H0005) if **provided by the same practitioner on the same date of service**. A different Credentialed Addiction Treatment Professional can provide opioid counseling and bill for H0004 or H0005 on the same date of service that the buprenorphine waived practitioner is providing the MAT induction (H0014). The buprenorphine waived practitioner who is providing physician induction services (H0014) and psychotherapy or opioid counseling (H0004 or H0005) within their scope of practice and meet the criteria as a Credentialed Addiction Treatment Profession as defined in Chapter IV of the ARTS Provider Manual, may provide these services **as long as they are provided on separate days**, as long as there is supporting documentation. The buprenorphine waived practitioner who is providing follow up/maintenance physician services (E&M office visit codes) and psychotherapy or opioid counseling (H0004 or H0005) within their scope of practice and meet the criteria as a Credentialed Addiction Treatment Profession as defined in Chapter IV of the ARTS Provider Manual, **may provide these services on the same days as long as there is supporting documentation**.
- Take home doses have a maximum 28-day limit (one-month supply) dispensing at a time.
- Buprenorphine-waivered practitioners at OTPs are required to complete service authorizations for prescriptions of buprenorphine products to be filled at a pharmacy unless the OTP applies and becomes recognized as a Preferred OBOT.

Preferred Office Based Opioid Treatment (OBOT) Services

Preferred OBOT service components and risk management requirements shall include the following activities. Providers must document the provision of the following activities, as rendered, in the member's medical record:

- Develop the initial assessment within 24 hours of initiation of services and document on the DMAS OBOT Initial ISP within 7 calendar days from intake.
- Develop and maintain the DMAS Individualized Plan of Care (IPOC) within 30 calendar days from the ISP assessment date and ongoing every 30 calendar days using the DMAS IPOC form.
- Ensure access to emergency medical and psychiatric care.
- Establish affiliations with more intensive levels of care such as intensive outpatient programs and partial hospitalization programs that unstable members can be referred to when clinically indicated.
- Provide individualized, patient-centered multidimensional assessment and treatment.

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- Assess, order, administer, reassess, and regulate medication and dose levels appropriate to the member; supervise withdrawal management from opioid analgesics; and oversee and facilitate access to appropriate treatment for opioid use disorder and alcohol use disorder.
- Ensure medication for other physical and mental illnesses are provided as needed either on-site or through collaboration with other providers.
- Ensure buprenorphine products are only dispensed on-site during the induction phase. After induction, buprenorphine products should be prescribed to the member.
- Ensure buprenorphine monoprodukt is only prescribed in the following scenarios: when a patient is pregnant, when converting a patient from methadone to buprenorphine/naloxone for a period not to exceed 7 days, or in formulations other than tablet form for indications approved by the FDA (pursuant to Board of Medicine regulations). All other members should be prescribed buprenorphine/naloxone products.
- Ensure that the maximum daily buprenorphine or buprenorphine/naloxone dose does not exceed 16 mg unless there is documentation of an ongoing compelling clinical rationale for a higher maintenance dose up to maximum of 24 mg.
- Due to a higher risk of fatal overdose when opioids are prescribed with benzodiazepines, sedative hypnotics, carisoprodol, and tramadol, the prescriber shall only co-prescribe these substances when there are extenuating circumstances and shall document in the medical record a tapering plan to achieve the lowest possible effective doses if these medications are prescribed (pursuant to Board of Medicine regulations).
- Provide cognitive, behavioral, and other substance use disorder-focused therapies, reflecting a variety of treatment approaches, to the member on an individual, group, or family basis by Credentialed Addiction Treatment Professionals, practicing within the scope of their license, working in collaboration with the prescribing buprenorphine-waivered practitioner. The Credentialed Addiction Treatment Professional **must be co-located at the same practice site** and provide counseling when the buprenorphine-waivered practitioner is prescribing buprenorphine or naltrexone to members with moderate to severe opioid use disorder.
 - Community Service Boards(CSBs)/Behavioral Health Authorities (BHAs) and Federally-Qualified Health Centers are not required to have the Credentialed Addiction Treatment Professional co-located at the same practice site and providing counseling during clinic sessions when the buprenorphine-waivered practitioner is prescribing buprenorphine or naltrexone products to members with opioid use disorder. The Credentialed Addiction Treatment Professional must be employed by the same organization and providing counseling to members prescribed buprenorphine or naltrexone products. They must engage in interdisciplinary care planning with the buprenorphine-waivered practitioner

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including working together to develop and monitor individualized and personalized treatment plans that are focused on the best outcomes for the member.

- Counseling can be provided via telemedicine in rural areas if the nearest Credentialed Addiction Treatment Professional is located more than 60 miles away from the buprenorphine-waivered practitioner. The Credentialed Addiction Treatment Professional must develop a shared care plan with the buprenorphine-waived practitioner and the member and take extra steps to ensure that substance use care coordination and interdisciplinary care planning are occurring.

Preferred OBOT shall include the following risk management activities which shall be documented in each member's record:

- Random urine drug screens, conducted a minimum of 8 times per year for all members with at least some tests unannounced or random.
- Virginia Prescription Monitoring Program checked at least quarterly for all members.
- Opioid overdose prevention education including the prescribing of naloxone for all members.
- At least weekly visits by the buprenorphine-waivered practitioner or Credentialed Addiction Treatment Professional during the first three months when initiating treatment. Member must be seen at least weekly for at least 3 months with documented clinical stability before spacing out to a minimum of monthly visits with buprenorphine-waivered practitioner or Credentialed Addiction Treatment Professional. The IPOC must be updated to reflect these changes.
- Periodic monitoring of unused medication and opened medication wrapper counts when clinically indicated.

Service Units and Limitations

- See ARTS Reimbursement Structure for billing codes and units for Preferred OBOT services available online: http://www.dmas.virginia.gov/Content_pgs/bh-sud.aspx.
- Preferred OBOT's physician and physician extender who are buprenorphine waived may bill the H0014 MAT induction code for three separate inductions per 365 calendar days per member that must be at least 90 calendar days apart. H0014 includes the physician/physician extender services only. This does not cover the medications as part of the induction. The first day of each separate induction is billed using H0014. Additional physician/nurse practitioner/physician assistant follow up and maintenance visits within a 365 calendar day period shall be billed using the appropriate evaluation and management code. Thus providers would submit H0014 for day one of induction,

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and the appropriate evaluation and management code on day two and after. Providers can bill for additional inductions beyond 3 separate inductions per 365 calendar days using the appropriate evaluation and management codes. If a member fails three buprenorphine or buprenorphine/naloxone inductions within a 365 calendar day period in a Preferred OBOT setting, the provider should consider referring the member to an OTP or higher level of care for assessment for treatment.

- Group psychotherapy and counseling by a Credentialed Addiction Treatment Professional, with a maximum of 10 members in the group. Such counseling shall focus on the needs of the members served.
- For substance use counseling and psychoeducational groups, the recommended group size limit is 10 but DMAS will allow for a larger group with the expectation that group size and composition should be based on the needs of the group members and determined using standards of care.
- The buprenorphine waived practitioner **shall not bill** for the MAT induction (H0014)) and psychotherapy or opioid counseling (H0004 or H0005) if **provided by the same practitioner on the same date of service**. A different Credentialed Addiction Treatment Professional may provide opioid counseling and bill for H0004 or H0005 on the same date of service that the buprenorphine waived practitioner is providing the MAT induction (H0014). The buprenorphine waived practitioner who is providing physician induction services (H0014) and psychotherapy or opioid counseling (H0004 and H0005) within their scope of practice and meet the criteria as a Credentialed Addiction Treatment Profession as defined in Chapter IV of the ARTS Provider Manual, may provide these services **as long as they are provided on separate days** as long as there is supporting documentation. The buprenorphine waived practitioner who is providing follow up/maintenance physician services (E&M office visit codes) and psychotherapy or opioid counseling (H0004 or H0005) within their scope of practice and meet the criteria as a Credentialed Addiction Treatment Profession as defined in Chapter IV of the ARTS Provider Manual, **may provide these services on the same days as long as there is supporting documentation**.
- Credentialed buprenorphine waived practitioners at Preferred OBOTs do not require service authorizations for prescriptions of oral buprenorphine products except for non-preferred buprenorphine products and buprenorphine products with a daily dose greater than 16 mg. The buprenorphine implant requires a service authorization which is available at http://www.dmas.virginia.gov/Content_pgs/bh-sa.aspx.

Preferred MAT in ASAM LEVELS 2.1 through 3.7

MAT can be billed separately from the per-diem ARTS payments in community-based settings providing ASAM Levels 1.0 through 3.7 (excluding inpatient services where it is included in the per diem ARTS payment). See the MAT chart in the appendix of this supplement for

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instructions on how to bill for physician visits, psychotherapy, medication, laboratory tests, and urine drug screens for MAT inductions and ongoing assessments and monitoring.

The benefit of the Preferred MAT Provider status is that buprenorphine waived practitioners will not have service authorizations for oral buprenorphine products that are on the DMAS Preferred Drug List or MCO formulary with a daily dose of 16 mg or less. There is no change to reimbursement for Preferred MAT Providers – they cannot bill the higher reimbursement rates for MAT inductions and opioid counseling or the substance use care coordination code. These codes can only be billed by OTPs and Preferred OBOTs. **Preferred MAT providers should adhere to the risk management strategies for Preferred OBOTs.**

Professionals who are providing services under arrangement with a residential treatment setting must follow the DMAS requirements noted in the **June 9, 2014 DMAS Provider Memorandum** to be reimbursed for these services separately from the per-diem rate paid to residential treatment facilities. The DMAS Memorandums are posted online at: www.virginamedicaid.dmas.virginia.gov.

In-Network Buprenorphine Waivered Practitioners Practicing Independently of an OTP/Preferred OBOT/Preferred MAT Setting

Practitioners of MAT must follow the Board of Medicine regulations for provisions for prescribing of buprenorphine for addiction treatment (12VAC85-21-130 to 170) including incorporating relapse prevention strategies into counseling or assure that they are addressed by a mental health service provider, as defined in § 54.1-2400.1 of the Code of Virginia, who has the education and experience to provide substance use disorder counseling.

Buprenorphine waived practitioners who are not employed by an OTP or Preferred OBOT credentialed with the MCOs or the BHSA will have service authorization requirements for prescriptions of buprenorphine products. Service authorization requests must include the following:

- A documented diagnosis of Opioid Use Disorder;
- Documentation of ongoing psychological counseling;
- Medical justification for doses greater than 16 mg per day;
- Compliance with the Virginia Prescription Monitoring Program;
- Documentation of member's pregnancy if monoprodut is prescribed;
- Documentation of urine drug screens; and
- Documentation to support Non-Preferred agents (if applicable).

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The DMAS service authorization form for fee-for-service and GAP members are located online at: <https://www.virginiamedicaidpharmacyservices.com>. MCOs have their own service authorization forms posted on their provider websites but will accept the DMAS service authorization form for buprenorphine oral products and the buprenorphine implant. The provider records must contain all information as required under the Board of Medicine regulations for provisions for prescribing of buprenorphine for addiction treatment (12VAC85-21-130 to 170).

Substance Use Care Coordination (G9012) for OTPs and Preferred OBOT Settings

Substance Use Care Coordination includes activities to ensure that necessary services, including mental health services, are integrated into primary care and specialty medical settings through interdisciplinary care planning and monitoring member progress, tracking member outcomes and reporting back to the buprenorphine-waivered practitioner and behavioral health professionals. Substance Use Care Coordination supports interdisciplinary care planning meetings between buprenorphine-waivered practitioners and licensed behavioral health professionals to develop and monitor the IPOC. Care coordination includes connecting members with community resources to facilitate referrals and respond to social service needs, as well as linking members with peer supports and tracking and supporting members when they obtain medical, behavioral health, or social services outside the practice.

The Preferred OBOT or OTP shall have a designated staff member who performs the following Substance Use Care Coordination functions:

- Meet face-to-face and utilize telephonic/collateral contacts with the member and significant others to facilitate recovery.
- Act as the primary point of contact for the member and the interdisciplinary team in the Preferred OBOT or OTP setting.
- Ensure that members have access (e.g., a telephone number, e-mail address) to their Substance Use Care Coordinator.
- Engage members in Substance Use Care Coordination activities as identified in the ISP for OTP settings and the IPOC in Preferred OBOT settings.
- Ensure that members have viable access to emergency services.
- Communicate with the member about their ongoing or newly identified needs on at least a monthly basis (or a frequency as requested by the member), to include a phone call or face-to-face meeting, depending on the member's needs and preferences.
- Notify members who their assigned care coordination contact is and if there needs to be a change, what is the plan for coverage.
- When possible, ensure continuity of care when care coordinator changes are made whether initiated by the member or by the Preferred OBOT or OTP.

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The staff member with the primary responsibility for Substance Use Care Coordination must execute the following responsibilities **at a minimum to support the monthly billing** of e Substance Use Care Coordination (G9012):

- Participate in interdisciplinary treatment team meetings for care planning at least once every 30 days for each member;
- Monitor the provision of services, including outcomes, assessing appropriate changes or additions to services, and facilitating referrals for the member;
- Ensure the ISP and the IPOCs are developed and updated as necessary;
- Ensure that appropriate mechanisms are in place to receive member input, complaints and grievances, and secure communication among relevant parties;
- Solicit and help support the member's wishes (e.g., health care decisions, prioritization of needs and implementation of strategies, etc.); and
- Provide education as needed to support informed decisions.

Service Units and Limits

- Only OTPs and Preferred OBOTs can bill for Substance Use Care Coordination.
- The initial and final months of treatment, Substance Use Care Coordination may be billed prior to the initial IPOC being completed, as long as the required activities noted above are provided and documented in the member's medical record for the billing month. The first IPOC must be finalized in the member's medical record within 30 calendar days from the ISP assessment date.
- Medicaid will not reimburse for Substance Use Care Coordination (G9012) if a member is in an ARTS Intensive Outpatient (ASAM Level 2.1), Partial Hospitalization (ASAM Level 2.5) or Inpatient/Acute Care (ASAM Level 4.0) setting.
- OTPs and Preferred OBOTs may bill for Substance Use Care Coordination if a member is also receiving Group Home (ASAM Level 3.1) services. Members should be seen at frequency as required earlier in this Supplement.
- Substance Use Case Coordination services are not reimbursable for members while they are residing in institutions, including Residential (ASAM Level 3.3, 3.5, 3.7), except that Substance Use Case Coordination may be reimbursed during the month prior to discharge to allow for discharge planning. This is limited to two one-month periods during a 12-month period. The monthly IPOC and care coordination activities must be documented to support the billing of the Substance Use Care Coordination to transition member from residential setting to community and re-engagement to the Preferred OBOT or OTP.

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- Substance Use Care Coordination (G9012) cannot be provided nor reimbursed for during the same month if member is receiving Substance Use Case Management (H0006). The member has a choice of provider for these services.
- CSBs/BHAs that are licensed as Substance Use Case Management providers may choose to provide either Substance Use Case Management services (H0006) or Substance Use Case Coordination (G9012) and must follow the program requirements for billing.

The chart below details the provider type requirements and procedures codes for Substance Use Care Coordination and Substance Abuse Case Management. Billing for Substance Use Care Coordination may be through the Buprenorphine Waivered Practitioner or the Licensed Credentialed Addiction Treatment Professional.

Service	Provider Requirements	Code/Unit	Who Provides the MAT?
Substance Use Care Coordination	OBOT OTP	G9012 1 unit = 1 month	<ul style="list-style-type: none"> • OBOT • OTP
Substance Abuse Case Management	DBHDS SA Case Management licensed provider	H0006 1 unit = 1 month	<ul style="list-style-type: none"> • Any Buprenorphine waived practitioner • OBOT • OTP

Preferred OBOTs and OTPs Interdisciplinary Plan of Care (IPOC) for Substance Use Care Coordination

Preferred OBOTs are required to complete the OBOT IPOC. OTPs who are billing for Substance Use Care Coordination (G9012) are also required to use the DMAS IPOC. The IPOC is a comprehensive treatment plan specific to the member's unique treatment needs as identified in the assessment or the multidimensional assessment as applicable to the ASAM Level of Care. The IPOC is person-centered, recovery oriented, includes all planned interventions, aligns with the member's identified needs, including care coordination needs and recovery goals, is regularly updated as the member's needs and progress change, and shows progress throughout the course of treatment. The written IPOC contains, but is not limited to, the member's treatment or training needs, the member's goals, measurable objectives and recovery strategies to meet the identified needs, services to be provided with the recommended frequency to accomplish the measurable goals and objectives, the estimated timetable for achieving the goals and objectives, and an individualized discharge plan that describes transition to other appropriate services. For persons with co-occurring psychiatric and substance use conditions, providers are expected to integrate the treatment needs in the member's IPOC.

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Preferred OBOTs and the Initial ISP

Preferred OBOTs shall develop the initial ISP within 24 hours of admission by a Credentialed Addiction Treatment Professional based on the ASAM multidimensional assessment to address the immediate service needs, health, and safety needs of the member at the initial point of contact. A licensed Credentialed Addiction Treatment Professional must sign off on the ISP if developed by a Certified Substance Abuse Counselor (CSAC). This shall be documented on the DMAS OBOT ISP form in the member's medical record and support the development of the Interdisciplinary Plan of Care (IPOC).

Preferred OBOTs/OTPs and the IPOC

The IPOC shall be developed and documented within 30 calendar days from the ISP assessment by a Credentialed Addiction Treatment Professional to address needs specific to the member's unique treatment as identified in the assessment or the multidimensional assessment as applicable to the ASAM Level of Care. A licensed Credentialed Addiction Treatment Professional must sign off on the Initial IPOC if developed by a Certified Substance Abuse Counselor (CSAC). The adult member shall sign his or her own IPOC and if unwilling or unable to sign the IPOC, then the service provider shall document the reasons why the member was not able or willing to sign the IPOC. The child's or adolescent's IPOC shall be signed by the parent/legal guardian except in cases where a minor has been deemed an adult for purposes of consenting to medical or health services needed for treatment of substance use disorder services meets requirements per [§54.1-2969](#).

The IPOC is considered meeting the comprehensive ISP requirements and shall be reviewed and completed every 30 calendar days from the date of the development of the initial ISP, at the interdisciplinary treatment team meetings and must be added to the member's medical record no later than 7 days from the calendar date of the review. This will be evidenced by the dated signatures of the Credentialed Addiction Treatment Professional as noted above, and the member and/or guardian, when a minor child is the recipient (unless meeting [§54.1-2969](#)). The IPOC shall be modified as the needs and progress of the member changes. If the review identifies any changes in the member's progress and treatment needs, the goals, objectives, and strategies of the IPOC must be updated to reflect any changes in the member's progress and treatment needs as well as any newly-identified problems.

While the IPOC is an essential documentation and planning tool required to bill Substance Use Care Coordination, it is only the written representation of the interdisciplinary treatment team meetings, which should occur no less often than every 30 days for each individual member. Completion of the IPOC shall support the monthly billing of the Substance Use Care Coordination (G9012). The 30-day review requirement for the IPOC, counts towards the 90-day ISP review requirement.

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In OBOT settings where no single staff member functions as the designated care coordinator and care coordination activities are conducted by multiple members of the care team, the interdisciplinary treatment team meeting may be the only recurring opportunity for team members to come together to share information, and develop a care plan that truly incorporates and addresses the member's ongoing needs.

Individual Service Plans (ISPs) for Opioid Treatment Program (OTPs) and Independent Buprenorphine Waivered Practitioners

OTPs who are not providing and billing for Substance Use Care Coordination may follow the ISP requirements below versus the DMAS IPOC as stated above. OTPs shall create and update an ISP that meets all criteria contained in the Department of Behavioral Health and Developmental Services Regulations for Licensing Providers (12VAC35-105-660-675).

OTPs and Independent Buprenorphine Waivered Practitioners shall meet the DMAS requirements noted below for ISPs.

The ISP consists of two different types:

- Initial ISP
- Comprehensive ISP

The initial ISP shall be developed and documented within 24 hours of admission by a Credentialed Addiction Treatment Professional based on the ASAM multidimensional assessment to address the immediate service needs, health, and safety needs of the member at the initial point of contact. A licensed Credentialed Addiction Treatment Professional must sign off on the ISP if developed by a Certified Substance Abuse Counselor (CSAC).

The comprehensive ISP shall be developed and documented within 30 calendar days from the assessment date by a Credentialed Addiction Treatment Professional to address needs specific to the member's unique treatment as identified in the assessment or the multidimensional assessment as applicable to the ASAM Level of Care. A Licensed Credentialed Addiction Treatment Professional must sign off on the ISP if developed by a CSAC. The ISP is person-centered, recovery oriented, includes all planned interventions, aligns with the member's identified needs and recovery goals, care coordination needs, is regularly updated as the member's needs and progress change, and shows progress throughout the course of treatment. The written ISP contains, but is not limited to, the member's treatment or training needs, the member's goals, measurable objectives and recovery strategies to meet the identified needs, services to be provided with the recommended frequency to accomplish the measurable goals and objectives, the estimated timetable for achieving the goals and objectives, and an individualized discharge plan that describes transition to other appropriate services. For persons

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with co-occurring psychiatric and substance use conditions, providers are expected to integrate the treatment needs in the member's ISP.

The adult member shall sign his or her own ISP and if unwilling or unable to sign the ISP, then the service provider shall document the reasons why the member was not able or willing to sign the ISP. The child's or adolescent's ISP shall be signed by the parent/legal guardian except in cases where a minor who is deemed an adult for purposes of consenting to medical or health services needed for treatment of substance use disorder services meets requirements per [§54.1-2969](#).

Documentation of the ISP review every 90-days from the development of the comprehensive ISP must be added to the member's medical record no later than 7 days from the calendar date of the review as evidenced by the dated signatures of the Credentialed Addiction Treatment Professional as noted above, and the member and/or guardian, when a minor child is the recipient (unless meeting [§54.1-2969](#)).

DOCUMENTATION REQUIREMENTS

Providers shall be required to maintain documentation detailing all relevant information about the Medicaid members who are in the provider's care. Such documentation shall fully disclose the extent of services provided in order to support provider's claims for reimbursement for services rendered. This documentation shall be written and dated at the time the services are rendered. Claims that are not adequately supported by appropriate up-to-date documentation may be subject to recovery of expenditures.

Progress Notes

In addition to the ISP and/or IPOC requirements detailed previously in this Supplement, providers must maintain appropriate progress notes. Progress notes shall disclose the extent of services provided and corroborate the units billed. Claims not supported by corroborating progress notes may be subject to recovery of expenditures. "Progress notes" means member specific documentation that is unique to the particular member's circumstances, treatment, and progress that is also signed and contemporaneously dated by the provider's professional staff who have prepared the notes and are part of the minimum documentation requirements that convey the member's status, staff intervention, and as appropriate, the individual's progress or lack of progress toward goals and objectives in the ISP and/or IPOC. The progress notes shall also include, at a minimum, the name of the service rendered, the date of the service rendered, the signature and credentials of the person who rendered the service, the setting in which the service was rendered, and the amount of time or units/hours required to deliver the service. The content of each progress note shall corroborate the time/units billed for each rendered service. Progress notes shall be documented for each service that is billed.

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When a member is discharged from the service, the provider shall document in the member's record the date of the discharge, reason for discharge, provide summary of the services provided as well as referrals or follow-up recommendations.

Substance Use Care Coordination

In order to be reimbursed for Substance Use Care Coordination (G9012), the OTP or OBOT must document the following:

- Development and monitoring of the individualized IPOC every 30 calendar days. These documents should reflect progress made toward specific, time limited and personalized goals and reflect the contributions and efforts made on behalf of the member by the interdisciplinary treatment team (including buprenorphine-waivered practitioners, Credentialed Addiction Treatment Professionals, allied health care professionals, and other relevant personnel involved in providing and coordinating the member's care). Providers must document activities to address all elements identified in the IPOC that is posted on the DMAS website at: http://www.dmas.virginia.gov/Content_pgs/bh-pm.aspx.
- Interdisciplinary care planning should consist of at least monthly meetings of the interdisciplinary treatment team (including all relevant medical and behavioral health care professionals involved in providing and coordinating the member's care) and documented in the IPOC and the progress notes.

The purpose of the interdisciplinary treatment team meeting includes:

- Review of the member's complete medical record (including urine drug screens and laboratory tests);
 - Discussion of the current status of member's progress toward meeting their goals as specified in their plan of care;
 - Particular attention should be paid to any barriers toward the member's progress in meeting their identified treatment goals as well as the actions which will be undertaken by the treatment team to address those barriers;
 - Identification of any new problems and/or goals and modification of the IPOC action plan accordingly.
 - A reassessment of the member's status utilizing the ASAM placement criteria's multidimensional assessment process and determine if a change in the ASAM Level of Care is required.
- Substance Use Care Coordination must include the appropriate use of and facilitation of referral to a variety of community based support modalities, including consideration of referral to 12 step and other self-help programs, peer recovery services, social service agencies, and other community based resources appropriate to the member's recovery.

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Referrals to community programs and services must be documented in progress notes and tracked. All efforts to help the member address any barriers to access of appropriate community based referrals such as transportation issues, must be documented as well.

- Substance Use Care Coordination also must include supporting the member's medical, behavioral health, and other health care needs through facilitation of necessary referrals to help meet the overall biopsychosocial needs to the member. This should include addressing needs beyond the member's medical status and include issues such as unstable housing, food insecurity, child care, and other social determinants of health. Subsequent referrals must be documented and tracked. Also, efforts to assist the member in addressing any barriers to completing the recommended referrals, such as transportation issues, must be documented.
- All contacts with the member regarding the overall care plan should be documented, as well as efforts to educate the member regarding treatment planning, the importance of treatment plan adherence and timely reporting of all updates and concerns should be documented. Safety plans must be documented as well as alternative plans for coverage of critical services in the event of provider unplanned unavailability.

Risk Management for Preferred OBOT and OTPs

Preferred OBOT and OTPs shall include the following activities which shall be documented in each member's record:

- Random urine drug screens, conducted a minimum of 8 times per year for all members with at least some tests unannounced or random.
- Virginia Prescription Monitoring Program checked at least quarterly for all members.
- Opioid overdose prevention education including the prescribing of naloxone for all members.
- At least weekly visits by the buprenorphine-waivered practitioner or Credentialed Addiction Treatment Professional during the first three months when initiating treatment. Member must be seen at least weekly for at least 3 months with documented clinical stability before spacing out to a minimum of monthly visits with buprenorphine-waivered practitioner or Credentialed Addiction Treatment Professional. The IPOC must be updated to reflect these changes.
- Periodic monitoring of unused medication and opened medication wrapper counts when clinically indicated.

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BILLING, PROCEDURE CODES AND REIMBURSEMENT

The licensed behavioral health provider providing the psychotherapy component for opioid treatment must be co-located at the same practice site as the buprenorphine waived practitioner and providing psychotherapy at the same location where the buprenorphine waived practitioner is prescribing buprenorphine or naltrexone to patients with opioid use disorder. This also applies for CSACs providing substance use disorder counseling or psychoeducational activities. The licensed behavioral health provider in an OBOT or OTP setting, if billing independently from the buprenorphine waived practitioner, must submit claims coinciding with the buprenorphine waived practitioner to support member is receiving the required psychotherapy and substance use counseling services along with the practitioner services.

The ARTS specific procedure codes and reimbursement structure are documented online at: http://www.dmas.virginia.gov/Content_pgs/bh-home.aspx.

PATIENT UTILIZATION AND SAFETY MANAGEMENT PROGRAM (PUMS)

All contracted Medicaid managed care plans including Medallion 3.0 and Commonwealth Coordinated Care Plus (CCC Plus) are required to have a Patient Utilization & Safety Management Program (PUMS). Note: Neither the CCC plans (Medicare/Medicaid Plans) nor Magellan of Virginia have the PUMS requirements. The PUMS program is intended to coordinate care and ensure that members are accessing and utilizing services in an appropriate manner in accordance with all applicable rule and regulations. The PUMS Program is a utilization control and case management program designed to promote patient safety and support proper medical management of essential health care. Upon the member's placement in the PUMS, the Contractor must refer members to appropriate services based upon the member's unique situation.

Placement into a PUMS Program

Members who are prescribed Buprenorphine contacting products will be placed into a PUMS program for a period of twelve (12) months. Once a member meets the PUMS placement requirements, the MCO may limit a member to a single primary care provider, controlled substances prescriber, hospital (for non-emergency hospital services only) and/or, on a case-by-case basis, other qualified provider types as determined by the MCO and the circumstances of the member. The MCO shall limit a member to providers that are credentialed in their network.

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Medication Assisted Treatment Provided Simultaneously and Approved to be Reimbursed Separately from other ASAM Levels of Care								
MAT Services	Procedure Code	ASAM Level 2.1 and 2.5	ASAM Level 3.1 Group Home	ASAM Level 3.3 RTS	ASAM Level 3.5 RTS	ASAM Level 3.5 Inpt Psych Unit	ASAM Level 3.7 RTS	ASAM Level 3.7 Inpt Psych Unit
Practitioner Induction Day 1	OBOT/OTP -H0014 Non OBOT/OTP = E&M Codes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Practitioner Visits after Day 1 (OBOT/OTP and non- OBOT/OTP)	E&M Codes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Psychotherapy* for MAT	CPT Psychotherapy Codes	No, included in IOP/PHP rate	Yes	Yes	Yes	Yes	Yes	Yes
Medications	Prescription filled at Pharmacy or Dispensed on site = HCPCS Codes S0109/J0571/J0572 /J0573/J0574/J0575/J2315	Yes	Yes	Yes	Yes	No	Yes	No
Urine drug screens	80305 - 80307	Yes	Yes	Yes	Yes	No	Yes	No
Labs	CPT Codes	Yes	Yes	Yes	Yes	No	Yes	No
Care Coordination	G9012	No, included in IOP/PHP rate	Yes	No	No	No	No	No

*MAT psychotherapy must be provided through the provider of ASAM Level of Care 2.1 – 4.0 and requires a Credentialed Addiction Treatment Professional practicing within the scope of their license. This does not replace the minimum requirements for psychotherapy as required in RTS. Professionally qualified practitioners affiliated with RTS providers may bill additional psychotherapy as an ancillary service.

Appendix

Appendix

Medication Assisted Treatment (MAT) – Outpatient Settings <i>Not OTP/OBOT Settings</i>		
Billing Code	Service Name	Authorization Required
99201- 99205	Evaluation and management services new patient	No
99211- 99215	Evaluation and management services established patient	No
82075	Alcohol Breathalyzer	No
80305- 80307	Presumptive drug class screening, any drug class	No
G0480- G0483	Definitive drug classes	No
86592 86593 86780	RPR Test	No
86704 86803 86701 86702 86703	Hepatitis B and C / HIV Tests	No
81025	Pregnancy Test	No
86580	TB Test	No
93000 93005 93010	EKG	No
90832 – alone or GT (w/o E&M)	Psychotherapy, 30 minutes with patient and/or family member	No
90833 – alone or GT (w/ E&M)	Psychotherapy, 30 minutes with patient and/or family member when performed with an evaluation and management service	No

Appendix

Medication Assisted Treatment (MAT) – Outpatient Settings – non OTP/OBOT Settings continued		
Billing Code	Service Name	Authorization Required
90834 – alone or GT (w/o E&M)	Psychotherapy, 45 minutes with patient and/or family member	No
90836 – alone or GT (w/ E&M)	Psychotherapy, 45 minutes with patient and/or family member when performed with an evaluation and management service	No
90837 – alone or GT (w/o E&M)	Psychotherapy, 60 minutes with patient and/or family member	No
90838 – alone or GT (w/ E&M)	Psychotherapy, 60 minutes with patient and/or family member when performed with an evaluation and management service	No
90846 – alone or GT	Family psychotherapy (without patient present)	No
90847 – alone, GT or HF if SA	Family psychotherapy (with patient present)	No
90853 – alone, GT or HF if SA	Group psychotherapy (other than multi-family)	No
90863 – alone, GT or HF if SA	Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services	No
Q3014 – GT	Telehealth originating site facility fee	No